Supreme Court, U.S.
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IN THE

Supreme Court of the United States

PACIFICARE BEHAVORIAL HEALTH OF CALIFORNIA,
PACIFICARE OF CALIFORNIA, INC.,
PACIFICARE HEALTH SYSTEMS, INC.,

Petitioner,

v.

LISA ELLEN SMITH,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO
THE CALIFORNIA COURT OF APPEAL

BRIEF IN OPPOSITION OF RESPONDENT LISA ELLEN SMITH

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STATEMENT OF THE CASE

California statutes regulate arbitration clauses in health plans by requiring the plan documents to include certain disclosures. These disclosure requirements apply to plans issued by traditional indemnity insurers and to plans issued by health maintenance organizations (called health care service plans in California.)

Indemnity insurers in California are regulated by the Commissioner of Insurance and the Insurance Code, while health care service plans are regulated by the Director of Managed Health Care and the Health & Safety Code.

The bill requiring the arbitration disclosures in health plans (Stats. 1994, c. 653 (A.B. 3260) contained separate, largely identical sections dealing with insurers and health care service plans. The provision pertaining to insurers was codified as § 10123.19 of the Insurance Code. The provision pertaining to health care service plans was codified as § 1363.1 of the Health & Safety Code.

Petitioner Pacificare Behavioral Health of California is a health care service plan. It is undisputed that the health plan it sold to respondent Lisa Smith did not comply with the requirements of Health & Safety Code § 1363.1.

Smith filed an action against the plan and its related entities (collectively "Pacificare") in the Superior Court of California for tortious denial of plan benefits. The Pacificare defendants moved to compel arbitration, and Smith resisted the

petition based on Pacificare's failure to comply with § 1363.1. The trial court denied the petition to compel arbitration (App. 36) and Pacificare appealed.

REASONS WHY THE WRIT SHOULD BE DENIED

A. The Court's decision in *Rush Prudential HMO v. Moran* has settled that HMOs are engaged in the business of insurance

The first question presented in Pacificare's petition is "are health care service plans 'insurance' under the McCarran-Ferguson Act, 15 U.S.C. § 1012?" *Rush Prudential HMO v. Moran*, __ U.S.__, __ S.Ct. __, 2002 WL 1337696 (2002), squarely answers that question in the affirmative. *Moran* holds that an Illinois statute regulating HMOs qualifies as a law that regulates insurance under ERISA's saving clause.

While *Moran* is an ERISA decision, its reasoning is equally applicable to cases arising under the McCarran-Ferguson Act. "The ERISA saving clause . . . appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States. The saving clause and the McCarran-Ferguson Act serve the same federal policy and utilize similar language to define what is left to the States." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744, 105 S.Ct. 2380, 2391 (1985). *Moran* therefore fully answers the first question presented in the petition.

B. There is no need for this Court to clarify the standards it has articulated to determine whether a state law regulates insurance

Pacificare's fall-back position is that this Court should grant certiorari to "clarify" the standards used to determine whether a state law regulates insurance. But there is no ambiguity in the standards and Pacificare's petition does not suggest that any ambiguity exists.

The California appellate court carefully articulated and applied this Court's precedents. (App. 20-28.) Pacificare simply disagrees with the lower court's conclusions and asks this Court to correct what it sees as error. It is Smith's understanding that this Court is reluctant to grant certiorari simply to correct the mis-application of a properly stated rule of law. Sup. Ct. R. 10.

This case involved the interpretation the first clause of section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b), which is highlighted below. The first clause confers on the states the right to regulate the business of insurance. The full text of section 2(b) says:

> ***No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance***, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance:

> Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended [15 U.S.C.A. 41 et seq.], shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

Two decisions by this Court have specifically construed the first clause of section 2(b) of the Act — *Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453, 459, 89 S.Ct. 564 (1969), and *United States Dept. of Treasury v. Fabe*, 508 U.S. 491, 499, 113 S.Ct. 2202 (1993). Both decision are analyzed extensively in decision below. (App. 21-27.) Both decisions turned on what state laws qualified under the Act as a "state law enacted for the purpose of regulating the business of insurance."

National Securities did not purport to define the outer contours of which state laws qualified for the Act's protection, but it explained that the "core" of the business of insurance involved "[t]he relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement . . . ." 393 U.S. at 459, 460. Hence, laws regulating these aspects of relationship between the insurer and its insured fall within the Act's protection.

Fabe applied the *National Securities* test, and it also analyzed the state law in question using a three-factor test developed in decisions construing the second clause of section 2(b) the Act. That clause creates an exemption to the federal antitrust laws for conduct by private parties (typically insurers) when they are engaged in the "business of insurance." *See Group Life & Health* v. *Royal Drug Co.*, 440 U.S. 205, 99 S.Ct. 1067 (1979), and *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 102 S.Ct. 3002 (1982). The three factors are whether (1) the practice spreads risk, (2) forms an integral part of the policy relationship between the insurer and the insured, and (3) is limited to entities within the insurance industry. *Id.* at 129.

The Court's ERISA precedents rely, in part, on a flexible application of this three-factor test to determine whether a state law "regulates insurance" and is therefore within the scope of the ERISA saving clause. *UNUM Life Ins. Co. of America v. Ward* 526 U.S. 358, 373, 119 S.Ct. 1380 (1999).

In the decision below the California Court of Appeal analyzed Health & Safety Code § 1363.1 under both the *National Securities* test and the three-factor test, and found that it passed muster under either approach. (App. 22-34.)

Since the court below applied both tests, as this Court did in *Fabe*, it is not clear what Pacificare would have this Court "clarify." Pacificare has not demonstrated any need for this Court to grant its petition, other than to reach a different outcome.

C. The court below correctly held that § 1363.1 was a state law that regulated insurance

Moran explains that under both ERISA and the McCarran-Ferguson Act state laws survive preemption if they regulate insurers with respect to their insurance practices. *Moran*, 2002 WL 1337696 at *7. *Moran* establishes that HMOs are "insurers." *Id.* at *10. The remaining question, then, is whether § 1363.1 regulates their insurance practices. The Court of Appeal correctly held that it does.

Section 1363.1 tells HMOs what language they must include in their plan documents – the enrollment form and the policy itself – if they wish to use binding arbitration. The statute's regulatory focus therefore falls squarely within what *National Securities* called the "core" of the business of insurance: the relationship between the insurer and its insured, the type of policy that can be issued, and its enforcement.

Application of the three-factor test leads to the same conclusion, as the Court of Appeal explained. While the California statute may not spread risk, it does regulate an integral part of the policy relationship between the insurer and its insured; indeed it regulates the very words that may permissibly be used in the policy. This satisfies the second factor.

The third factor is satisfied as well, because the statute regulates only entities within the insurance industry — HMOs.

Since, as in *Ward* and *Moran*, the statute satisfies two of the three factors, it satisfies the flexible McCarran-Ferguson Act test. *Moran*, 2002 WL 1337696 at *10, citing *Ward*, 526 U.S. at 373. The Court of Appeal was therefore correct in finding that the McCarran-Ferguson Act shielded § 1363.1 from preemption by the Federal Arbitration Act.

CONCLUSION

Since *Moran* resolves the first question raised in the petition, and the second question is simply a request that this Court correct what Pacificare perceives as a misapplication of the three-factor test, there is no compelling reason for the Court to grant the petition.

Respectfully submitted,

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